



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Prior Authorization

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## Revision History

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5.0	Policies and procedures as of December 1, 2020 Published: March 18, 2021	Scheduled update: <ul style="list-style-type: none"> <li>• Edited text as needed for clarity</li> <li>• Replaced DXC references with Gainwell, and references to the PA Unit with PAUM</li> <li>• Removed references to the <i>Medical Policy Manual</i></li> <li>• Added notes about UnitedHealthcare being added as MCE</li> <li>• Updated instructions for requesting PA criteria in the <a href="#">Prior Authorization Policy Requirements</a> section</li> <li>• Clarified the additional documentation requirements in the <a href="#">Provider Types Allowed to Submit PA Requests</a> section</li> <li>• In the <a href="#">Time Parameters for Prior Authorization Requests</a> section, changed “business days” to “calendar days” and specified phone options</li> </ul>	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> <li>• In the <a href="#">Updating PA Requests</a> section, clarified that the PA must be active and current, and retroactive changes to start dates are not allowed</li> <li>• Updated the <a href="#">Procedures for Submitting PA Update Requests</a> section</li> <li>• Updated fax instructions in the <a href="#">Submitting PA Requests by Mail or Fax</a> section</li> <li>• Added Portal file-size limits in the <a href="#">Attachments</a> section</li> <li>• Updated information in the <a href="#">Telephone PA Procedures</a> section to reflect new phone line</li> <li>• Updated the mailing address in the subsections under <a href="#">Administrative Hearing Appeal Process for PA Decisions</a></li> </ul>	

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# Section 1: Introduction to Prior Authorization

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*Note: The information in this document applies to prior authorization for Indiana Health Coverage Programs (IHCP) nonpharmacy services. For information about pharmacy-related prior authorization, see the [Pharmacy Services](#) module.*

*Although this module contains some general information regarding prior authorization for services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual for policies and procedure specific to each health plan. MCE contact information is included in the [IHCP Quick Reference Guide](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

*For updates to information in this module, see [IHCP Banner Pages and Bulletins](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

The Indiana Health Coverage Programs (IHCP) requires prior authorization (PA) based on medical necessity for certain services. Certain services also require submitting PA requests for additional units when normal limits are exhausted.

The *Indiana Administrative Code* (IAC) serves as a primary reference for IHCP covered services and PA procedures and parameters. IHCP providers are responsible for reading the portions of the IAC that apply to their specific areas of service as well as the PA criteria found in 405 IAC 5-3.

Together with the IAC, the following resources provide a complete reference for IHCP PA policies and procedures:

- Code of Federal Regulations (CFR)
- Indiana Code (IC)
- Publications on the [Provider References](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers):
  - IHCP provider reference modules
  - IHCP bulletins and banner pages
- Publications by entities contracted to provide PA for services delivered under a managed care program

## Prior Authorization Contractors

Multiple entities provide PA for IHCP services. The first step in determining which entity to contact for PA is establishing whether the service is reimbursed through the fee-for-service (FFS) or managed care delivery system, as described in the following sections.

Contact information for all IHCP PA contractors is available in the [IHCP Quick Reference Guide](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

## Fee-for-Service Prior Authorization

For services delivered on an FFS basis (such as under the Traditional Medicaid program), the PA contractors are as follows:

- For pharmacy services – OptumRx
- For all other services – Gainwell Technologies (formerly DXC Technology)

*Note: For brokered nonemergency medical transportation (NEMT) services, Southeastrans is responsible for obtaining PA through Gainwell, as needed. Transportation providers are not required to submit PA requests when the service is brokered through Southeastrans. See the [Transportation Services](#) module for more information.*

The Gainwell Prior Authorization and Utilization Management (PAUM) Unit reviews all PA requests on an individual, case-by-case basis. The unit's decisions to authorize, modify, or deny a given request are based on medical reasonableness, necessity, and other criteria in the IAC, as well as FSSA-approved internal criteria.

See the [Pharmacy Services](#) module for more information about pharmacy-related PA.

## Managed Care Prior Authorization

For services covered under the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise programs, the managed care entities (MCEs) or their subcontractors are responsible for processing PA requests and notifying members about PA decisions. Each MCE (Anthem, CareSource, MDwise, and Managed Health Services [MHS]) may develop its own internal criteria for 405 IAC rule compliance.

*Note: UnitedHealthcare will also be an MCE for Hoosier Care Connect beginning April 1, 2021.*

MCEs are responsible for determining which services require PA for their members, excluding those services that are carved out of managed care and covered under the FFS delivery system. PA requests for services carved out of managed care are processed through Gainwell and are subject to the same criteria as FFS requests. See the [Member Eligibility and Benefit Coverage](#) module for a list of services that are carved-out of managed care.

Additional information about MCE authorization procedures can be requested from the member's assigned MCE or the MCE's dental benefit manager (DBM) or pharmacy benefit manager (PBM). MCE assignment information is provided during eligibility verification via the IHCP [Provider Healthcare Portal](#) (Portal), accessible from the home page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers); the Interactive Voice Response (IVR) system at 1-800-457-4584; or the 270/271 electronic transaction. Contact information for all MCEs and their subcontracted DBM and PBM is available in the [IHCP Quick Reference Guide](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

## Transferring Outstanding Prior Authorizations

If a member changes from managed care (with an MCE assignment) to fee-for-service (no MCE assignment) or from fee-for-service to managed care – or if a managed care member switches from one MCE to another – the member's new PA contractor must honor all existing PAs for one of the following durations, whichever comes first:

- The first 30 calendar days, starting on the member's effective date in the new plan
- The remainder of the PA dates of service
- Until approved units of service are exhausted



This policy extends to PAs for a specific procedure (such as a surgery), as well as for ongoing services authorized for a specified duration (such as physical therapy or home health care). MCEs may be required to reimburse out-of-network providers during the transition period.

Providers should always check eligibility before rendering services. If there has been a change in the member's MCE assignment, providers should notify the new PA contractor of any outstanding PAs and supply documentation to substantiate the PA.

The entity that issued the original PA is required to provide the newly assigned PA entity with the following information:

- Member's IHCP Member ID (also known as RID)
- Provider's National Provider Identifier (NPI)
- Procedure codes
- Duration and frequency of authorization
- Other information pertinent to the determination of services provided

*Note: If, in addition to a change in MCE assignment, the member's coverage has also changed (for example, from Full Medicaid to HIP Basic, or from Package A to Family Planning Eligibility Program), the authorized service must be a covered service under the new benefit plan assignment for IHCP reimbursement of the previously authorized service. **PA is not a guarantee of payment.***

## Prior Authorization Policy Requirements

Criteria pertaining to PA requirements can be found in 405 IAC 5. Information about how this code applies to specific IHCP services is included in the appropriate IHCP provider reference modules, available from the [IHCP Provider Modules](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). This module provides some general PA guidelines, but the IAC and applicable provider reference modules should be referred to as the primary references for PA policy.

Providers can obtain applicable sections of the FFS internal PA criteria by referring to the appropriate provider reference module or by submitting a request to the Office of Medicaid Policy and Planning (OMPP) as described on the [Policy Consideration Requests](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

*Note: For HIP, Hoosier Care Connect, and Hoosier Healthwise members, MCEs may develop their own internal criteria for 405 IAC rule compliance.*

### ***Prior Authorization Policies for Out-of-State Providers***

All services provided by out-of-state providers require PA, except in the circumstances presented in the [Out-of-State Providers](#) module.

## Prior Authorization Exceptions

The following PA exceptions are described in 405 IAC 5-3-12:

- School corporation services do not require a separate PA procedure, because the Individualized Education Program (IEP) serves as the PA. See the [School Corporation Services](#) module for details.
- When a member's physician determines that an inpatient hospital setting is no longer necessary but that IHCP-covered services should continue after the member is discharged, up to 120 hours of such services may be provided within 30 days of discharge without prior authorization, if the physician has specifically ordered such services in writing upon discharge from the hospital. This exemption does not apply to durable medical equipment, neuropsychological and psychological testing, or out-of-state medical services. Physical, speech, respiratory, and occupational therapies may continue for a period not to exceed thirty 30 hours, sessions, or visits in 30 days without prior authorization if the physician has specifically ordered such services in writing upon discharge or transfer from the hospital. See the [Home Health Services](#) and [Therapy Services](#) module for details.
- Emergency services do not require PA. Providers must follow the guidelines outlined in the [Emergency Services](#) module.

*Note: Although emergency services do not require PA, any resulting inpatient stay does require PA, with the exception of inpatient stays for burn care with an admission of type 1 (emergency) or type 5 (trauma). All other emergency admissions must be reported to the PA contractor within 48 hours of admission, not including Saturdays, Sundays, or legal holidays, as indicated in the [Inpatient Hospital Services](#) module.*

## 590 Program

PA requirements for the 590 Program differ from those of other IHCP programs. For 590 Program members, PA is required for any service estimated to be \$500 or more, and PA is not required (unless rendered by an out-of-state provider) for any service estimated to be less than \$500. See the [590 Program](#) module for more information.

## Prior Authorization Required for Specific Medical Services

Specific PA criteria for physician services are found in 405 IAC 5-25. In addition, as specified in 405 IAC 5-3-13(a), the following medical services require PA:

- Reduction mammoplasties
- Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem
- Intersex surgery
- Blepharoplasties for significant obstructive vision problems
- Sliding mandibular osteotomies for prognathism or micrognathism
- Reconstructive or plastic surgery
- Bone marrow or stem-cell transplants
- All organ transplants covered by the Medicaid program
- Home health services
- Maxillofacial surgeries related to diseases of the jaws and contiguous structures
- Temporomandibular joint (TMJ) surgery
- Submucous resection of nasal septum and septoplasty when associated with significant obstruction

- Weight reduction surgery, including gastroplasty and related gastrointestinal surgery
- Procedures ordinarily rendered on an outpatient basis, when rendered on an inpatient basis
- Dental admissions
- Brand medically necessary drugs
- Psychiatric inpatient admissions, including admissions for substance abuse
- Rehabilitation inpatient admissions
- Orthodontic procedures for members under 21 years of age for cases of craniofacial deformity or cleft palate
- Genetic testing for detection of cancer of the breasts or ovaries
- Medicaid Rehabilitation Option (MRO) services, except for crisis intervention
- Partial hospitalization, as provided under 405 IAC 5-20-8
- Neuropsychological and psychological testing

*Note: Any physician services that require but do not receive PA are not reimbursed, including services rendered during an office visit and services rendered during an inpatient hospital stay paid for under a level-of-care (LOC) methodology – such as psychiatric, rehabilitation, and burn stays.*

## Prior Authorization Limitations for Reimbursement

The IHCP does not reimburse providers for any IHCP service requiring PA unless PA is obtained first. If a PA request qualifies for retroactive eligibility, as defined in the [Retroactive Prior Authorization](#) section of this module, a determination must be made prior to submitting a claim. PA is monitored by concurrent or postpayment review. Exceptions to this policy are noted later in this document.

Any authorization of a service by an IHCP PA contractor is limited to authorization for payment of IHCP allowable charges. It is not an authorization of the provider's estimated fees.

**PA is not a guarantee of payment.** Notwithstanding any PA by the IHCP, the provision of all services and supplies must comply with the following resources:

- IHCP Provider Agreement
- IHCP provider reference modules
- IHCP Bulletins
- IHCP Banner Pages
- Remittance Advice (RA) statements or 835 transactions
- PA criteria requested by and issued to providers
- Any applicable state or federal statute or regulation



## Section 2: Prior Authorization Procedures

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The Indiana Health Coverage Programs (IHCP) requires prior authorization (PA), based on medical necessity, for certain services. Certain services also require submitting PA requests for additional units when normal limits are exhausted. Providers must verify eligibility before delivery of a service and must monitor the number of units of each prior-authorized service.

### Prior Authorization and Eligibility Verification

The PA contractor determines whether a PA request is approved, based on medical necessity. Granting PA confirms medical necessity, but is valid only if a member is eligible on the date services are rendered. Providers can verify eligibility by using the Interactive Voice Response (IVR) system, Provider Healthcare Portal (Portal), or 270/271 electronic transaction. See the [Member Eligibility and Benefit Coverage](#) module for details about verifying member eligibility.

*Note: It is not the responsibility of the PA contractor to ensure the eligibility status of a member. PA is not a guarantee of payment, and member eligibility should be verified by the provider before services are rendered.*

The eligibility verification process also helps providers determine which entity to contact for PA, based on whether the member's benefits are provided through a managed care program. For managed care members, the eligibility verification provides the name of the managed care program – Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise – and the name and contact information of the managed care entity (MCE) to which the member is assigned. See the [Prior Authorization Contractors](#) section for information about obtaining PA under FFS versus managed care delivery systems.

Providers should also determine whether the member has third-party liability (TPL) coverage and whether PA from the third-party carrier is necessary. Because the IHCP is the payer of last resort, claims must be submitted to the third-party carrier before they are submitted to the IHCP. The third-party carrier, as well as the IHCP, may require PA. See the [Prior Authorization and Third-Party Liability](#) section for more information.

### Provider Requests for Prior Authorization

Providers can request PA on behalf of the IHCP member. See [Section 3: Methods for Submitting Prior Authorization Requests](#) for information about submitting PA requests electronically, by fax, by mail, or (when applicable) by telephone.

After PA is obtained, the member can choose the provider that will render the authorized service, as long as the member is not restricted to a specific provider of service, such as members enrolled in the Right Choices Program (RCP) and members assigned to a primary medical provider (PMP) within a managed care program. It is important to note that the member may have a prior-authorized service performed by a physician other than the one who requested the PA; the approved PA belongs to the *member*, not to the provider.

*Note: If a member has other health insurance, and a service that is covered by Medicaid requires PA from both payer sources, the provider must obtain PA from both sources before rendering services.*

## ***Provider Types Allowed to Submit PA Requests***

In accordance with *Indiana Administrative Code 405 IAC 5-3-10*, PA requests can be signed and submitted by the following provider types:

- Doctor of medicine (MD)
- Doctor of osteopathy (DO)
- Dentist
- Optometrist
- Podiatrist
- Chiropractor
- Psychologist endorsed as a health service provider in psychology (HSPP)
- Home health agency (authorized agent)
- Hospital (authorized agent)
- Transportation provider (authorized agent)
- For drugs subject to prior authorization, any provider with prescriptive authority under Indiana law

If a PA request is submitted without a signature (as defined in the following section) from a provider described in the preceding list, the PA is suspended for proof of physician signature.

If a provider type other than those listed previously submits a PA request electronically (via the Portal or 278 transaction), the requester must submit a physician's order, signed and dated by the physician. This additional documentation may be uploaded as an attachment to the Portal request, or else must be sent by fax or mail. Unless the attachment is submitted via the Portal at the time the request is made, the original request is suspended for documentation of the physician's order. Failure to submit additional documentation within 30 calendar days of the request results in denial of the request.

## ***PA Signature Policies***

Pursuant to *405 IAC 5-3-5(c)(2)*, the provider must sign the PA request by personal signature, or providers and their designees may use a signature stamp or, for requests submitted via the Portal, an electronic signature. Providers that are agencies, corporations, or business entities may authorize one or more representatives to sign requests for PA.

Electronic signatures are accepted on supporting documents as long as the provider's electronic health record system provides the appropriate protection and assurances that the rendering provider signed the document and the signature can be authenticated. If the appropriate controls are in place, electronic signatures are acceptable. Providers using electronic systems need to recognize the potential for misuse or abuse with alternate signature methods. Providers bear the responsibility for the authenticity of the documentation and signatures. Physicians are encouraged to check with their attorneys and malpractice insurers regarding electronic signatures. Any provider using an electronic signature must follow the requirements of *Indiana Code IC 26-2-8-116*.

## Time Parameters for Prior Authorization Requests

*Note: The information in this section is specific to FFS PA. For managed care PA requests, contact the appropriate PA contractor for authorization time parameters and related procedures.*

The decision regarding a PA request is made as quickly as possible. For FFS nonpharmacy requests, if a decision is not made within **7 calendar days** after receipt of all required documentation, authorization is deemed to be granted within the coverage and limitations specified (405 IAC 5-3-14).

The provider must wait until notification of approval (via PA notification letter, Portal authorization status, or the 278 response) before billing for the service, or until verification can be made that Gainwell received the request and did not render a decision within the time parameters listed previously. Verification is accomplished by using the [Provider Healthcare Portal](#) View Authorization Status page (available from the Care Management tab) or the IVR system (available from the Customer Assistance line at **1-800-457-4584**, option 2 followed by option 5). To speak with a live representative regarding a PA request, select option 7 on the Customer Assistance line.

## Suspension for Requests of Additional Information

For the PA reviewer to determine whether a service or procedure is medically reasonable and necessary, the PA contractor may request more information from the member and provider. Additional clinical information to justify medical necessity or additional information needed for clarification – including, but not limited to, x-rays, ultrasound, lab, and biopsy reports – may be required. Photographs may be necessary in some instances, such as breast reduction surgery or wound management. Other reasons a PA request may require additional information include lack of complete medical history, missing medical clearance forms, or missing plan of treatment.

When additional information is requested, the time parameters as described previously begin on receipt of the information by the PA contractor. The established mechanism to allow time for the provider to supply this information is achieved by *suspending* the first request and having the provider submit the additional information as follows:

- Through the Portal (for FFS PA), by uploading the supporting documentation as a system update to the suspended authorization request. See the [Update PA Requests on the Portal](#) section for details.
- By mail or fax, using the *IHCP Prior Authorization System Update Request Form*, available on the [Forms](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

*Note: Suspending the request does not mean the request is denied; it gives the provider additional time to provide clinical information that facilitates a more accurate and appropriate determination.*

The PA contractor must receive this additional information within 30 calendar days of the request. If the PA contractor determines medical necessity after receiving the additional information, the dates authorized are those on the originally suspended PA request. If the additional information is not received within 30 days, the request is systematically denied.

If the determination involves a denial or modification of a continuing service, such as home health care, at least 10 days' notice plus 3 days' additional mailing time must be given before the effective date of the change begins.

## New PA Requests for Ongoing Services

The provider is responsible for submitting new PA requests for ongoing services at least 30 calendar days before the current authorization period expires to ensure that services are not interrupted.

## Supporting Documentation

Depending on the type of service requested, various supporting documents must be included with the PA request, such as a current plan of treatment, progress notes, and medical documentation.

Certain types of supporting documentation must be submitted using designated forms, available on the [Forms](https://in.gov/medicaid/providers) page at [in.gov/medicaid/providers](https://in.gov/medicaid/providers).

### ***Medicaid Second Opinion Form***

Providers may be required to submit a second or third opinion to substantiate the medical necessity of certain services. If required, the *Medicaid Second Opinion Form* should be completed as directed in the form's narrative and submitted to the appropriate PA contractor based on the program assignment of the member. Completed forms may be submitted by fax or by mail, or (for FFS requests only) uploaded as an attachment to the PA request submitted via the Portal.

### ***Medical Clearance Forms for DME or Medical Supplies***

Providers must submit medical clearance forms to justify the medical necessity of designated DME or medical supplies when requesting PA. DME or medical supplies that require medical clearance forms when requesting PA include, but are not limited to, the following services:

- Augmentative communication devices – *Augmentative Communication System Selection Form*
- Home oxygen therapy – *Certification of Medical Necessity: Oxygen*
- Parenteral or enteral nutrition – *Certification of Medical Necessity: Enteral and Parenteral Nutrition*
- Hearing aids – *Medical Clearance and Audiometric Test Form*
- Hospital and specialty beds – *Medical Clearance Form for Hospital and Specialty Beds*
- Motorized wheelchairs or other power-operated vehicles – *Medical Clearance Form for Motorized Wheelchair Purchase*
- Negative pressure wound therapy – *Medical Clearance Form for Negative Pressure Wound Therapy*
- Nonmotorized wheelchairs – *Medical Clearance Form for Nonmotorized Wheelchair Purchase*
- Standing equipment – *Medical Clearance Form for Standing Equipment*
- Transcutaneous electrical nerve stimulator (TENS) units – *Medical Clearance Form for TENS Unit*

When requesting PA for the DME or medical supplies listed in this section, providers must complete the appropriate clearance form and attach it to a completed *IHCP Prior Authorization Request Form* or (for FFS requests only) upload it as an attachment to the PA request submitted via the Portal. Failing to provide appropriate medical clearance forms with a PA request results in suspension, not denial, of the PA request. Forms should be completed in sufficient detail to enable a decision about medical reasonableness and necessity.

**Providers should retain for their records photocopies of any medical clearance forms included with their submissions.** PA contractors can receive the completed medical clearance forms by fax or mail – or, for FFS requests, as attachments uploaded via the Portal.



## Prior Authorization Request Status and Notification Letter

After a decision is reached about an FFS PA request, the Core Medicaid Management Information System (CoreMMIS) automatically generates an *Indiana Medicaid Prior Authorization Notification* letter (PA notification letter). If the PA request is not approved, additional information is included with the notification letter to explain the decision, such as the following:

- For modified and denied decisions, IAC references and administrative review and appeal rights are included in the letter.
- For suspended requests, the letter explains what additional information is required (see the [Suspension for Requests of Additional Information](#) section of this module).
- If the PA request is rejected, the PA notification letter notes that the PA was submitted to the wrong PA contractor based on the assignment of the member to a specific IHCP program.

PA notification letters are mailed to the member and the *requesting* provider. The provider's copy of the PA notification letter is sent to the mail-to address on file for the requesting provider. The rendering provider, if different from the requesting provider, must contact either the requesting provider or the member to secure a copy of the PA notification letter.

An explanation of the *Indiana Medicaid Prior Authorization Notification* letter content follows:

- The top-left area of the form provides requesting provider and member information.
- Specific information about the requested service is provided below the provider and member information.
- Space for narrative about the decision is provided below the service information.

Providers can check the status of FFS, nonpharmacy requests using any of the following methods:

- Online, by logging in to the [Provider Healthcare Portal](#) and selecting *View Authorization Status* from the Care Management tab (The provider must have a PA number or be the requesting or rendering provider listed on the PA to use this option.)
- Via 278 electronic transaction, as described in the [278 Response](#) section
- By phone, using the IVR system, available at 1-800-457-4584, option 2 and then option 5)

[Table 1](#) provides a list of *Health Insurance Portability and Accountability Act* (HIPAA)-compliant PA status responses provided by the Portal, 278 transaction, or IVR system and the associated administrative working status responses provided in the PA notification letter. **Providers should refer to their PA notification letters for additional information regarding the more detailed working status of a PA request.**

**Table 1 – HIPAA-Compliant PA Status Responses Crosswalked with Associated Administrative Working Statuses**

<b>PA Status in the Portal/278</b>	<b>Action Code on the 278 Transaction</b>	<b>PA Status in the IVR</b>	<b>PA Status in Notification Letters (Clarification)</b>	<b>PA Status Code</b>
Certified in Total	A1	“...is approved.”	Approved	A
			Appr Thru Admin Rev (Approved through administrative review)	Y
			Appr/Contin of Serv (Approved for continuation of service)	F
			Auto Appr After 10 (Automatically approved after 10 days)	Z
			Dec Overturn by ALJ (Decision overturned by administrative law judge)	C
			Dis No Hearing Appr (Appeal dismissed, no hearing, request approved)	S
			Non-Cov Code Approve (Noncovered code, approved)	B
Modified	A5	“...is modified.”	Dis No Hearing Mod (Appeal dismissed, no hearing, request modified)	T
			Mod Thru Court (Decision modified through court action)	V
			Modified	M
			Mod/Contin of Serv (Modified for continuation of service)	G
			Mod Thru Admin Rev (Modified through administrative review)	X
No Action Required	NA	“...is not assigned; request does not require PA.”	No PA required	N
			No PA Req for PMP (No PA required when requested by a PMP)	O

PA Status in the Portal/278	Action Code on the 278 Transaction	PA Status in the IVR	PA Status in Notification Letters (Clarification)	PA Status Code
Not Certified	A3	"...is denied."	Dis No Hearing Den (Appeal dismissed, no hearing, request denied)	U
			Dec Upheld by ALJ (Decision upheld by administrative law judge)	W
			Denied	D
			Den/Contin of Serv (Denied for continuation of service)	H
			Incorrect PMP	Q
			Non-Cov Code Denied (Noncovered code, denied)	I
Pended	A4	"...is rejected."	Rejected	R
		"...has been suspended for further information."	Suspended (Suspended for further review)	K
		"...is pending written documentation."	Pending (Pending receipt of required information)	P

If a provider checks on the status of a PA request while it is still in the process of being reviewed, and it has not been suspended for further review and is not pending receipt of written documentation, the IVR system responds that the request "is in evaluation." On the Portal, the Status field will be blank when a request is in evaluation.

## Updating PA Requests

Certain authorization information can be updated on an *existing* PA request, instead of by submitting another PA request. PA updates may be requested by fax, by mail, and, in some cases, by telephone. For FFS authorizations, the update can be submitted via the Portal. The following are examples of appropriate PA update requests:

- A provider that discovers a **clerical error in the PA data entered** may perform a system update through the Portal (FFS only) or may call or write to request the correction, depending on the complexity of the situation. If the error does not require research or review of the original PA request, the correction can be updated over the telephone. However, some items may be too complicated to resolve with a telephone call and may require additional medical documentation to support the request. Providers may need to send the original request and the system-generated PA notification letter for review. An explanatory letter is helpful.
- A request to **increase home health services**, except in the case of urgent or emergency services, requires a written request with supporting documentation of medical necessity. This request and supporting documentation may be submitted by fax or mail, or (for FFS only) as a system update through the Portal.
- **Extending the dates on an approved surgery because rescheduling was necessary** is appropriate for a telephone update or (for FFS only) a system update through the Portal.

For all PA update requests, the PA must be active and current. Updates cannot be made to expired PAs, and retroactive changes cannot be made to PA start dates.

*Note: Any request for a **new** service must be submitted as a new PA request.*

## ***Procedures for Submitting PA Update Requests***

Authorization updates may be requested by fax, by mail, or, in some cases, by telephone. For FFS nonpharmacy authorizations, the requesting provider can perform a system update to the existing request through the Portal, as described in the [Update PA Requests on the Portal](#) section.

Written PA update requests may be submitted on the *IHCP Prior Authorization System Update Request Form*, available on the [Forms](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). Written PA update requests can also be submitted on the provider's letterhead, with **PRIOR AUTHORIZATION UPDATE** written boldly across the top. The following should be included with the PA update request:

- Pertinent information, such as member name, Member ID, and PA number
- Information to be corrected, changed, or updated
- A copy of the original PA request and system-generated PA notification letter to verify the item to be updated

Mail or fax written FFS, nonpharmacy PA update requests to the following address:

**Gainwell – Prior Authorization**  
**P.O. Box 7256**  
**Indianapolis, IN 46207-7256**  
**Fax: 1-800-689-2759**

When appropriate, FFS nonpharmacy PA update requests can be made by phone at 1-800-457-4584, option 7.

For managed care PA update procedures, contact the appropriate PA contractor.

## ***Prior Authorization Update Notification Letter***

When an existing FFS PA is updated, *CoreMMIS* automatically generates an *Indiana Medicaid Prior Authorization Update Notification* (PA update notification letter). A narrative at the bottom of this letter highlights the information that was changed.

The PA update notification letter includes the same types of information as appear on the PA notification letter (see the [Prior Authorization Request Status and Notification Letter](#) section for details).

## **Prior Authorization Procedures for Home and Community-Based Services Programs**

This section includes PA procedures for IHCP home and community-based services (HCBS) programs. As with any PA request, the requester must have a valid NPI that has been registered with the IHCP or, if an atypical provider, an IHCP Provider ID. The rendering provider must be enrolled in the IHCP to receive reimbursement for providing services to an IHCP member, ensuring that all service requirements are met.

## **1915(c) HCBS Waiver Authorizations**

In addition to waiver services, HCBS waiver members also receive Traditional Medicaid benefits, with the same PA requirements and procedures applying to those benefits as apply for other Traditional Medicaid members.

HCBS waiver program services are approved by the member's waiver program State administrator: the FSSA Division of Aging (DA), Division of Disability and Rehabilitative Services (DDRS), or Division of Mental Health and Addiction (DMHA). The approved waiver services are recorded on a Notice of Action (NOA), and the approved dollars listed on the NOA are transmitted to the member's PA history table to be used during the claim adjudication process. Any discrepancies between approved dollars for waiver services on the NOA and dollars available on the member's PA history table need to be mediated through the member's case manager, who facilitates the resolution of any discrepancies.

Some services may be available through both State Plan (Traditional Medicaid) benefits and waiver program benefits. In this case, the State Plan service benefits, including any that may be available through PA, must be exhausted first before obtaining waiver program services, even if the waiver services are approved.

See the [Home and Community-Based Services Billing Guidelines](#) module for more information.

## **1915(i) HCBS State Plan Authorizations**

The authorization process for HCBS 1915(i) services varies by program. For more information, see the following modules:

- [Division of Mental Health and Addiction: Adult Mental Health Habilitation Services](#)
- [Division of Mental Health and Addiction: Behavioral and Primary Healthcare Coordination Services](#)
- [Division of Mental Health and Addiction: Child Mental Health Wraparound Services](#)

## **Retroactive Prior Authorization**

PA is given after services have begun or supplies have been delivered only under the following circumstances:

- Pending or retroactive member eligibility
  - The PA request must be submitted within 12 months of the date when the member's caseworker entered the eligibility information. The hospice authorization request must be submitted within 1 year of the date nursing facility level of care is approved by the office.
- Mechanical or administrative delays or errors by the contractor or county office of the FSSA Division of Family Resources (DFR)
- Services rendered outside Indiana by a provider that had not yet enrolled as an IHCP provider
- Transportation services authorized under *405 IAC 5-30*
  - The PA request must be submitted within 12 months of the date of service.
- The provider was unaware that the member was eligible for services at the time services were rendered; PA is granted in this situation only if the following conditions are met:
  - The provider's records document that the member refused or was physically unable to provide his or her IHCP Member ID.
  - The provider can substantiate that reimbursement was continually pursued from the member until IHCP eligibility was discovered.
  - The provider submitted the request for PA within 60 calendar days of the date that IHCP eligibility was discovered.
- Any situation in which the physician cannot determine the exact procedure to be done until after the service has been performed

## Prior Authorization and Third-Party Liability

If the IHCP requires PA for a service, and the member has additional insurance coverage that is primary, the provider must follow the primary insurer's requirements for obtaining PA and must also obtain PA from the appropriate IHCP PA contractor (based on the program assignment of the member) to receive payment from the IHCP for the balance of charges not paid by the primary insurance.

IHCP PA and Medicare PA are not required for members with Medicare Part A and Part B coverage if the services are covered (in whole or in part) by Medicare. Services not covered by Medicare are subject to normal PA requirements.

See the [Third-Party Liability](#) module for more information.

## Section 3: Methods for Submitting Prior Authorization Requests

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Indiana Health Coverage Programs (IHCP) providers have multiple options for submitting prior authorization (PA) requests:

- Providers can submit PA requests by fax or by mail using the appropriate PA request form as described in the [Submitting PA Requests by Mail or Fax](#) section.
- Providers can submit FFS, nonpharmacy PA requests online using the IHCP Provider Healthcare Portal (Portal). Providers can also use the Portal to view the status of those requests. For detailed instructions, see the [Submitting PA Requests through the Portal](#) section.
- Providers can submit PA requests electronically through the 278 transaction. Attachments to the 278 transaction must be submitted separately, via fax or mail. See the [Submitting PA requests by 278 Electronic Transaction](#).
- In some cases, providers can submit PA requests by telephone. See the [Submitting PA Requests by Telephone](#) section for information on what services can be prior authorized over the telephone.

Providers can also use these options to submit updates to existing PA requests. See the [Updating PA Requests](#) section for more information.

To obtain information on PA submission and documentation procedures for services rendered under Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise managed care programs, providers should contact the appropriate MCE. Providers are responsible for using these tools to ensure accurate, timely PA review and claim processing.

### Submitting PA Requests by Mail or Fax

Providers can submit nonpharmacy prior authorization requests by mail or fax on one of the following forms:

- *IHCP Prior Authorization Request Form* (universal prior authorization form)
- *IHCP Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form*
- *IHCP Dental Prior Authorization Request Form*

Providers should retain photocopies of the completed PA request forms for their records. For FFS PA, fax or mail completed request forms to the following fax number or address:

**Gainwell – Prior Authorization**  
**P.O. Box 7256**  
**Indianapolis, IN 46207-7256**  
**Fax: 1-800-689-2759**

Each faxed submission must:

- Contain only one PA request or modification of an existing request, for one IHCP member, per provider
- Not exceed 999 pages, including supporting documents

The IHCP will not accept multiple PA requests (batched) within the same faxed submission or single requests that exceed 999 pages. A submission of more than 999 pages must be sent via mail or the Portal.

# Universal PA Request Form

The *IHCP Prior Authorization Request Form* is available on the [Forms](#) page at [in.gov/medicaid/providers](https://in.gov/medicaid/providers). Table 2 includes instructions for completing the form.

### Table 2 – IHCP Prior Authorization Request Form Instructions

[illegible]



Field	Description
Rendering Provider Information: <ul style="list-style-type: none"> <li>• Rendering Provider NPI/ Provider ID</li> <li>• Tax ID</li> <li>• Name</li> <li>• Address</li> <li>• City/State/ZIP Code</li> <li>• Phone</li> <li>• Fax</li> </ul>	Enter the information requested for each field, if the rendering provider is known at the time the request is completed. (The rendering provider is the physician or other IHCP-enrolled practitioner who will be delivering the service to the member.)  Enter the rendering provider's NPI or, for atypical providers that do not have an NPI, enter the rendering provider's IHCP Provider ID.
Ordering, Prescribing, or Referring (OPR) Provider Information: <ul style="list-style-type: none"> <li>• OPR Physician NPI</li> </ul>	Enter the NPI of the OPR provider. (The OPR provider is the practitioner that ordered, prescribed, or referred the member for the requested service.)
Preparer's Information: <ul style="list-style-type: none"> <li>• Name</li> <li>• Phone</li> <li>• Fax</li> </ul>	Enter the requested information about the person preparing the PA request.
Medical Diagnosis <ul style="list-style-type: none"> <li>• Dx1</li> <li>• Dx2</li> <li>• Dx3</li> </ul>	Enter the primary, secondary, and tertiary International Classification of Diseases (ICD) diagnosis codes.
Assignment Category	Check the assignment category for the service you are requesting.
Dates of Service, Start	Enter the requested start date for the service. (For continued services, the start date must be the day after the previous end date.)
Dates of Service, Stop	Enter the requested stop date of service.
Procedure/Service Codes	Enter the requested service codes, such as Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), revenue code, National Drug Code (NDC), and so forth.
Modifiers	Enter any applicable service code modifiers.
Service Description	Enter a short description (or include an attachment) of the requested services and like services provided by other payers.
Taxonomy	Enter any applicable taxonomy codes.
Place of Service (POS)	Enter the requested place of service.
Units	Enter the requested number of units. Units are equal to days, months, or items, whichever is applicable.
Dollars	Enter the estimated or known IHCP cost of the service. <b>Required for home health services and durable medical equipment (DME) requests.</b>
Notes	Enter clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan-of-treatment dates.  Your request <b>MUST</b> include medical documentation to be reviewed for medical necessity.

Field	Description
Mandatory Additional Documentation Checklist	<i>Note: This field is only on the Residential/Inpatient SUD Treatment PA Request Form.</i> Check each box to indicate that the required documentation is included with request. <b>Required.</b>
Signature of Qualified Practitioner	Authorized provider, as listed in the <a href="#">Provider Types Allowed to Submit PA Requests</a> section and 405 IAC 5-3-10, must sign and date the form. Signature stamps can be used. <b>Required.</b>
Date	

Before submitting the *IHCP Prior Authorization Request Form* by fax or mail, complete the following:

- Make sure the form has a signature and date from a qualified practitioner. The signature prevents the PA from being suspended and delaying services.
- Confirm that the Member ID (also known as RID) is correct.
- Confirm that the NPI or Provider ID is correct.
  - For FFS, the *requesting provider* is the billing entity, and the *rendering provider* is the individual provider performing the service.
    - Sole proprietors and group or corporate business entities, such as a DME supplier or hospital, must place their billing NPI or IHCP Provider ID in the **Requesting Provider NPI/Provider ID** field. The PA notification letter is mailed to the requesting provider's mail-to address.
    - The **Rendering Provider NPI/Provider ID** field should contain the NPI or Provider ID of the physician or other IHCP-enrolled practitioner within the group or corporate business entity that ordered the services, equipment, or supplies.

*Note: For sole proprietors or dual-status providers, the requesting provider and the rendering provider may be one and the same.*

- HIP, Hoosier Care Connect, and Hoosier Healthwise MCEs use claim-processing systems other than CoreMMIS. For this reason, the IHCP recommends that providers contact the appropriate MCE (Anthem, CareSource, MHS, or MDwise) to determine how to complete the Requesting Provider and Rendering Provider fields on the *IHCP Prior Authorization Request Form*.

*Note: UnitedHealthcare will also be an MCE for Hoosier Care Connect beginning April 1, 2021.*

- Confirm that all other information on the form is correct and complete. Remember that the ICD diagnosis code must be listed and procedure codes must be valid, including modifiers.
- To ensure that response letters are mailed to the appropriate location, verify that the requesting provider's mail-to address is correct in CoreMMIS. Providers may verify the accuracy of their mail-to address on file by using the Provider Maintenance link on the Portal or by calling Customer Assistance at 1-800-457-4584 (select option 2 and then option 3).

## ***Residential/Inpatient SUD Treatment PA Request Form***

The *IHCP Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form* is available on the [Forms](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). This form must be used instead of the standard universal PA request form to request PA for inpatient and residential SUD treatment services.

This form contains the same fields as the universal PA request form, plus a checklist for additional documentation that is mandatory for residential and inpatient SUD treatment requests. The instructions for completing the universal PA request form (in [Table 2](#)) are also applicable to this form. That table includes instructions for the additional field that is specific to this form.

## ***IHCP Dental Prior Authorization Request Form***

Table 3 contains instructions for the *IHCP Dental Prior Authorization Request Form*. The form as well as the instructions are available on the [Forms](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

Table 3 – *IHCP Dental Prior Authorization Request Form* Instructions

Field	Description
Requesting provider NPI (or IHCP Provider ID) Name Telephone Taxonomy Service location ZIP Code+4  Mail-to provider NPI (or IHCP Provider ID) Name Telephone Taxonomy Service location ZIP Code+4	<p>Enter the requesting or rendering provider's NPI (for atypical providers, enter the IHCP Provider ID), name, telephone number, taxonomy, and service location ZIP Code +4. The taxonomy is used to establish a one-to-one match with the NPI entered. If the requesting provider is not enrolled, the PA request form will be returned to the provider. <b>A valid NPI or Provider ID is required.</b></p> <p>The provider's copy of the <i>Indiana Medicaid Prior Authorization Notification</i> (PA notification letter) is sent to the address that corresponds to the requesting provider NPI/Provider ID in this field, unless a separate mail-to provider is identified on the form.</p> <p>If the requesting provider does not have a valid service location on file, a PA notification letter will not be generated.</p> <p>If the mail-to provider fields are completed in conjunction with the requesting provider information that has a valid service location, the address on file for the mail-to provider NPI/Provider ID will be selected as the mailing address for the PA notification letter, instead of the address on file for the requesting provider NPI/Provider ID.</p>
Member name Member address IHCP Member ID Member date of birth	<p>Enter the name, address, IHCP Member ID (also known as RID), and date of birth for the member who is to receive the requested service.</p>
Dates of service, Start	<p>Enter the requested start date for the service. (For continued services, the start date must be the day after the previous authorization end date.)</p>
Dates of service, Stop	<p>Enter the requested stop date for the service.</p>
Requested service, Procedure code	<p>Enter the requested service code, such as CPT, Current Dental Terminology (CDT), HCPCS, revenue code, or NDC.</p>
Requested service, Description	<p>Enter a short description (or include an attachment) of the requested service and like services provided by other payers.</p>
Place of service	<p>Enter the requested place of service.</p>
Units	<p>Enter the number of units desired. Units are equal to days, months, or items, whichever is applicable.</p>
Dollars	<p>Enter the estimated or known IHCP cost of the service. <b>Required for home health services, DME, and pharmacy requests.</b></p>
Caseworker Telephone	<p>Enter the caseworker's name and telephone number.</p>

Field	Description
MCE/590/FFS	Select the appropriate member plan, if applicable: <ul style="list-style-type: none"> <li>For managed care, select <b>MCE</b>.</li> <li>For the 590 program, select <b>590</b>.</li> <li>For fee-for-service plans, select <b>FFS</b>.</li> </ul>
Is member employed?	Select <b>YES</b> or <b>NO</b> .
Circumstances (place/type)	Enter employment information, if applicable.
Is member in job training?	Select <b>YES</b> or <b>NO</b> .
Type of job training	Enter training information, if applicable.
<b>Dental Treatment Plan</b>	
1. Endodontics	On the chart, indicate with a checkmark (✓) the tooth or teeth (1–32) to be treated by root-canal therapy.
2. Periodontics	Briefly summarize the periodontal condition.
3. Does the member have missing teeth?	Select <b>YES</b> or <b>NO</b> . If yes, indicate which teeth are missing with a checkmark (✓) on the diagram provided.
4. Partial dentures	Answer questions A through E as indicated. A. Date or dates of extractions of missing teeth. B. Which teeth are to be extracted? (List tooth numbers.) C. Which teeth are to be replaced? (List tooth numbers.) D. Brief description of materials and design of partial. E. Is member wearing partials now? ( <b>YES</b> or <b>NO</b> ) Age of present partials.
5. Dentures	Check one or both: Full upper denture, Full lower denture. Answer questions A through D as indicated: A. How long edentulous? B. Is member wearing dentures now? ( <b>YES</b> or <b>NO</b> ) Age of present dentures. C. Is the member physically and psychologically able to wear and maintain the prostheses? ( <b>YES</b> or <b>NO</b> ) D. Can the member's existing dentures be relined or repaired to extend their useful life? ( <b>YES</b> or <b>NO</b> )
6. Describe treatment if different from above	Describe any treatment to be provided that was not listed previously on this form.
7. Is the member on parenteral/enteral nutritional supplements?	Check <b>YES</b> or <b>NO</b> . If Yes, a plan of care to wean the member from the nutritional supplements must be attached. If the plan of care is not provided, dentures, partials, relines, and repairs will be denied.
8. Brief dental/medical history	Enter pertinent information known to the provider about the member's dental and medical history.
Signature of requesting dentist	The authorized provider, as listed in the <a href="#">Provider Types Allowed to Submit PA Requests</a> section, must sign the form. Signature stamps can be used.
Date of submission	Enter the date the form was actually submitted.

## Submitting PA Requests through the Portal

Registered Portal users with appropriate administrative permissions can log in to the provider account to submit FFS, nonpharmacy PA requests online. Information about registering a Portal account and assigning administrative permissions can be found in the [Provider Healthcare Portal](#) module.

*Note: FFS pharmacy prior authorizations are handled by the vendor OptumRx. MCEs handle PA for the members of their plan. PA requests for these services cannot be submitted through the Portal.*

After logging in to the Portal, users can access the prior authorization options (described in [Table 4](#)) from the Care Management tab on the Portal menu bar, either by clicking the tab to access the *Care Management* page or by placing the cursor over the tab to display a drop-down menu of options.

Figure 1 – Accessing Care Management Options for Prior Authorization

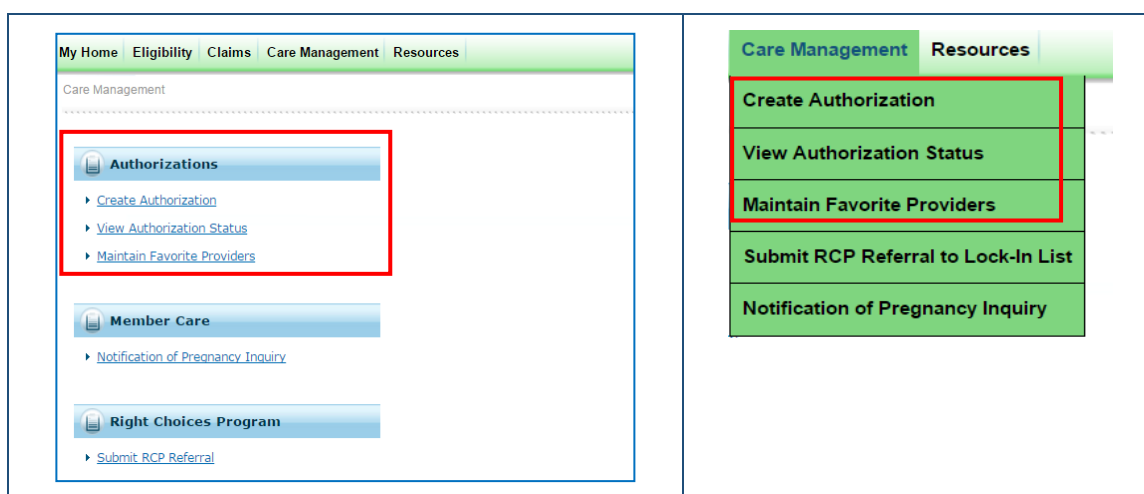


Table 4 – Care Management – Authorization Options

Link	Description
<b>Create Authorization</b>	Allows providers to submit FFS, nonpharmacy PA requests electronically through the Portal. This tool is designed to help IHCP providers file PAs faster and more easily. All information required for paper PA submissions is also required for Portal submissions.  <i>Note: Requests for drugs such as nonpreferred medications and the Medical Necessity Review Form for mental health medications cannot be submitted via the Portal.</i>
<b>View Authorization Status</b>	Existing FFS, nonpharmacy PAs can be viewed by entering criteria in the search fields: Authorization Number, Service Type, Service Date, Member ID, Birth Date, First/Last Name, Provider ID, or Type. PA requests submitted electronically during business hours are viewable within 2 hours of submission.
<b>Maintain Favorite Providers</b>	Up to 20 servicing providers may be added to the users favorites list from this link. The favorites list is designed to help a user store and retrieve frequently selected providers when creating PA requests.

## Create Authorization (Requesting PA)

Prior authorization requests can be ordered directly by the providers listed in the [Provider Types Allowed to Submit PA Requests](#) section; all other providers must include an attachment documenting that the service or supply is physician-ordered.

For convenience, multiple services can be added in one authorization request, and different rendering providers can be specified for each service.

Every authorization request has four panels to complete:

- Create Authorization
- Diagnosis Information
- Service Details
- Attachments

### Create Authorization

The *Create Authorization* panel includes four sections:

- **Requesting Provider Information:** This section displays information to identify the provider making the request.
- **Member Information:** This section requires the user to enter the member's Member ID and date of birth, and at least one character of the member's first name and last name. This information helps verify that the request is being made for the correct member.
- **Rendering Provider Information:** This section asks for rendering provider information, which is optional, and the service type, which is required.
  - If specifying a rendering provider for the authorization, choose one of the following methods to enter the information:
    - Click the Rendering Provider same as Requesting Provider checkbox.
    - Select the provider from the list of favorites (see [Maintain Favorite Providers](#)).
    - Click the magnifying glass icon to search for the desired provider.
    - Enter the Provider ID or NPI, ID type, and taxonomy (if needed) for the rendering provider.
  - In the **Service Type** field, select the appropriate type of service. The type of service selected will determine what fields and attachments are included for the request.
- **Message Information:** Although this section does not have any required fields, it can be used to add clinical summary information pertaining to this authorization request. Supporting information required for the request can either be entered in this field or attached as a separate document.

Figure 2 – Create Authorization Panel

**Create Authorization** ?

Any forms relating to Authorization requests can be found [here](#).

\* Indicates a required field. [Expand All](#) | [Collapse All](#)

---

**Requesting Provider Information** [-]

Requesting Provider Information

Provider ID  ID Type  NPI Taxonomy  Name

---

**Member Information** [-]

Enter Member ID, Date of Birth and at least one character of First and Last Name

\*Member ID  \*Birth Date

\*Last Name  \*First Name

---

**Rendering Provider Information** [-]

If you wish to enter a Rendering Provider for this Authorization, you can either click the checkbox to use the Requesting Provider, select the Rendering Provider from your list of Favorites or enter ID, ID Type and Taxonomy (as needed). You will have the option of selecting a different Rendering Provider for any Service Detail below. You MUST select a Service Type for this Authorization.

Rendering Provider same as Requesting Provider ☐

Select from Favorites

Provider ID  ID Type  Name

Taxonomy

\*Service Type

---

**Message Information** [-]

Enter any additional information concerning this Authorization request.

Message

## Diagnosis Information

In the *Diagnosis Information* panel, add a diagnosis type and code for the PA request, and then click **Add**. Multiple diagnosis codes can be entered by repeating the diagnosis entry procedure. The first diagnosis code will be considered the primary diagnosis for the request.

Figure 3 – Adding Diagnosis Information for the PA Request

**Diagnosis Information** [-]

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code. Click the **Remove** link to remove the entire row.

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	G114-Hereditary spastic paraplegia	<input type="button" value="Remove"/>

☐ Click to collapse.

Diagnosis Type  ICD-10-CM Diagnosis Code  G114-Hereditary spastic paraplegia

*Note: The Portal does not require the user to enter a diagnosis code when submitting a prior authorization request. However, applicable diagnosis codes may be required for the approval of PA requests for certain services.*

## Service Details

The *Service Details* panel asks for details about the services to be performed. Each service added requires the dates of service, procedure code and code type, and either units or dollars associated with the code. If appropriate, procedure code modifiers and place of service can also be indicated.

*Note: If the code entered is one that does not typically require PA, a pop-up message is displayed asking the user to confirm the entry. In certain situations, such as limitations audits, a provider may need to request authorization for a service that otherwise would not require PA. The provider may either proceed with or cancel the request, as appropriate.*

If the rendering provider for a service differs from the one used in the *Create Authorization* panel, use the fields in the Rendering Provider area to identify the provider for this specific service.

Click **Add** after completing this panel for each service being requested.

Figure 4 – Adding Service Details for the PA Request

The screenshot shows the 'Service Details' form. At the top, there is a header bar with the title 'Service Details'. Below the header, a instruction bar states: 'Click '+' to view or update the details of a row. Click '-' to collapse the row. Click Copy to copy or Remove to remove the entire row.' Below this is a table with columns: '+/-', 'From Date', 'To Date', 'Code', 'Modifiers', 'Units', and 'Action'. The table is currently collapsed. Below the table, there is a section for entering service details. It includes fields for 'From Date', 'To Date', 'Code Type' (a dropdown), and 'Code' (a text field). There are also fields for 'Modifiers' (two text fields), 'Units' (a text field), 'Dollars' (a text field), and 'Place of Service' (a dropdown). A 'Message' field is also present. Below these fields is a section for 'Rendering Provider (if different from above):'. It includes a 'Select from' dropdown, a 'Favorites' section, and fields for 'Provider ID' (with a search icon), 'ID Type' (a dropdown), 'Taxonomy' (a text field), and 'Name' (a text field). At the bottom of the form are two buttons: 'Add' and 'Cancel'.

*Note: The Portal is designed to accept either units or dollar amounts for all prior authorization requests.*



## Attachments

The *Attachments* panel allows the user to attach documents electronically to the authorization request. To upload an attachment to the Portal, follow these steps:

1. Select **FT-File Transfer** from the Transmission Method drop-down menu.
2. Click **Browse** to search for and select the desired files.
3. Select the type of document from the Attachment Type drop-down menu.
4. Click **Add**.

Figure 5 – Adding Attachments

*Note: The attachment file size limit is 5 MB and valid file types for upload include: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif, and .tiff.*

*If attachments must be sent by mail or fax instead of uploading them to the Portal, include a note in the **Message** field of the Create Authorization panel ([Figure 2](#)) indicating that supporting documents are on their way. A Prior Authorization System Update Request Form, available from the [Forms](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers), must be sent as a cover letter.*

## Completing the PA Request

After completing the four steps to request PA, click **Submit**. After the request passes the series of checks, the *Confirm Authorization* panel is displayed so that the information can be reviewed one last time.

- Click **Confirm** to send the request.
- Click **Back** to return to the previous panels and edit any information.
- Click **Cancel** to cancel the authorization request.

Figure 6 – Confirm Authorization

Confirm Authorization						
Review all information for the Authorization displayed below. If the information is correct, click the Confirm button. If you want to make any corrections to the Authorization, click the Back button. If you do not want to submit the Authorization request, click the Cancel button.						
<a href="#">Expand All</a>   <a href="#">Collapse All</a>						
<b>Requesting Provider Information</b>						
Provider ID	1001001001	ID Type	NPI	Taxonomy	Name	Rendering Provider
<b>Member Information</b>						
Member ID	100100100100	Member Name	Member Name	Birth Date	01/18/1962	Gender
<b>Rendering Provider Information</b>						
Provider ID	1001001001	ID Type	NPI	Taxonomy	100N11111X	Name
Service Type	DURABLE MEDICAL EQUIPMENT PURCHASE					
<b>Diagnosis Information</b>						
Diagnosis Type		Diagnosis Code				
ICD-10-CM		G114-Hereditary spastic paraplegia				
<b>Service Details</b>						
	From Date	To Date	Code	Modifiers	Units	Dollars
	07/17/2014	07/17/2014	CPT/HCPCS A9999-DME SUPPLY OR ACCESSORY, NOS		1.000	0
<b>Attachments</b>						
#	Transmission Method	File	Control #	Attachment Type		
1	FT-File Transfer	Physician Order.PNG (OK)	201507178381	D2-Physician Order		
<div>Back</div> <div>Confirm</div> <div>Cancel</div>						

After the PA submission is confirmed, an *Authorization Receipt* panel appears. The request is assigned an authorization tracking number to enable providers to track the status of the requested authorization.

Figure 7 – Authorization Receipt

Authorization Receipt		
Your Authorization Tracking Number 1000000084 was successfully submitted.		
Click <b>Print Preview</b> to view authorization details and receipt.		
Click <b>Copy</b> to copy member data or authorization data.		
Click <b>New</b> to create a new authorization for a different member.		
General Authorization Receipt Instructions		
<b>Print Preview</b>	<b>Copy</b>	<b>New</b>

## View Authorization Status

To find, review, and check the status of a previously submitted PA request, select **Care Management > View Authorization Status**. The *View Authorization Status* panel offers two ways to search for prior authorization requests: Prospective Authorizations and Search Options.

The **Prospective Authorizations** tab (Figure 8) lists up to 20 authorization requests for which the user is either the requesting or rendering provider and the service date is the current date or a date in the future. The list can be sorted by clicking the desired of the column header. To view authorization information for an item in the list, click the tracking number hyperlink in the Authorization Number column.

Figure 8 – Prospective Authorizations

View Authorization Status

Prospective Authorizations

Search Options

Prospective authorizations identifying you as the Requesting or Rendering Provider are listed below. These results include the first (20) authorizations with a beginning Services Date of today or greater. Click the Authorization Number to view the authorization response details or select the Search Options tab to search for a different authorization.

Authorization Number	Service Date ▲	Member Name	Member ID	Service Type	Requesting Provider	Servicing Provider
<a href="#">1000000065</a>	10/16/2009	Xxxxxx, Xxxxxx	xxxxxxxxxxxxxx	Mental Health	Plano Independent Hospital	County Hospital
<a href="#">1000000017</a>	10/16/2009 - 10/18/2009	Xxxxxxxxxx, Xxxx	xxxxxxxxxxxxxx	Hospital - Inpatient	Plano Independent Hospital	County Hospital
<a href="#">1000000062</a>	10/16/2009 - 10/18/2009	Xxxxxx, Xxxxxx	xxxxxxxxxxxxxx	Durable Medical Equipment Rental	Plano Independent Hospital	County Hospital
<a href="#">1000000061</a>	10/16/2009 - 10/20/2009	Xxxxxxxxxx, Xxxx	xxxxxxxxxxxxxx	Dental Care	Plano Independent Hospital	County Hospital
<a href="#">1000000063</a>	10/16/2009 - 10/20/2009	Xxxxxx, Xxxxxx	xxxxxxxxxxxxxx	Medical Care	Plano Independent Hospital	County Hospital
<a href="#">1000000064</a>	10/16/2009 - 10/20/2009	Xxxxxxxxxx, Xxxx	xxxxxxxxxxxxxx	Physical Therapy	Plano Independent Hospital	County Hospital
<a href="#">1000000066</a>	10/16/2009 - 10/20/2009	Xxxxxx, Xxxxxx	xxxxxxxxxxxxxx	Radiation Therapy	Plano Independent Hospital	County Hospital
<a href="#">1000000067</a>	10/16/2009 - 10/20/2009	Xxxxxxxxxx, Xxxx	xxxxxxxxxxxxxx	Home Health Care	Plano Independent Hospital	County Hospital

Use the **Search Options** tab (Figure 9) to search for older PA requests or requests not displayed in the Prospective Authorizations list.

- Enter the desired search information. You can search for authorizations by:
  - Authorization number
  - Service type
  - Day range or service date
  - Member information
  - Provider information
- Click **Search**.  
If information is missing or additional search fields are required, a message displays the error. Otherwise, a list of search results appears. The search results can be sorted by clicking the desired column header.
- From the resulting list, locate the desired request and click the appropriate link in the Authorization Number column.

Figure 9 – Authorization Search Options

**View Authorization Status**

Prospective Authorizations **Search Options**

Enter either the Authorization Number or at least one of the other fields to search for authorizations.

**Authorization Information**

Authorization Number

Service Type

Select a Day Range or specify a Service Date

Day Range  OR Service Date

**Member Information**

If member information is entered and the Member ID is not entered, then Last Name (at least 1 character), First Name (at least 1 character) and Birth Date are all required.

Member ID  Birth Date

Last Name  First Name

**Provider Information**

To narrow the search by Rendering Provider, enter the ID and ID Type or click on the magnifying glass to search for a provider.

Provider ID  ID Type

**Search** **Reset**

**Search Results**

Click on a Column Heading to change the sort order

Authorization Number	Service Date	Member Name	Member ID	Service Type	Requesting Provider	Rendering Provider
<a href="#">E151915191</a>	07/17/2015	MEMBER NAME	100100100100	SURGICAL	PROVIDER NAME	PROVIDER NAME
<a href="#">E151915192</a>	04/04/2015 - 10/04/2015	MEMBER NAME	100100100100	HOME HEALTH VISITS	PROVIDER NAME	PROVIDER NAME

After an authorization is selected, using either of the preceding methods, the *View Authorization Response* panel (Figure 10) displays the PA request information along with a status response (see Table 1) for each service detail.

Figure 10 – View Authorization Response

View Authorization Response for		Back to View Authorization Status ?				
<b>Authorization #</b> General Authorization Response Instructions <a href="#">Expand All</a>   <a href="#">Collapse All</a>						
<b>Requesting Provider Information</b>						
Provider ID	ID Type NPI	Taxonomy	Name			
<b>Member Information</b>						
Member ID	Member	Birth Date				
<b>Rendering Provider Information</b>						
Provider ID	ID Type	Taxonomy	Name			
<b>Message Information</b>						
Message						
<b>Diagnosis Information</b>						
Diagnosis Type	Diagnosis Code					
ICD-10-CM	F840-AUTISTIC DISORDER					
<b>Service Detail Information</b>						
<b>Service Details</b>						
	From Date	To Date	Code	Modifiers	Units	Status
+	01/12/2021	07/05/2021	CPT/HCPCS 97151-BHV ID ASSMT BY PHYS/QHP	U1	32	Modified
+	01/12/2021	07/05/2021	CPT/HCPCS 97153-ADAPTIVE BEHAVIOR TX BY TECH	U2	4000	Modified
-	01/12/2021	07/05/2021	CPT/HCPCS 97155-ADAPT BEHAVIOR TX PHYS/QHP	U1	800	Modified
Rqst From Date 01/04/2021 Rqst To Date 07/05/2021 Auth From Date 01/12/2021 Auth To Date 07/05/2021 Rqst Units 832 Rqst Dollars 0 Place of Service Auth Units 800 Auth Dollars 0 Denied/Rejected Reason Used Units 13 Used Dollars 338 Message 97155 BCBA 8 hours a week						
+	01/12/2021	07/05/2021	CPT/HCPCS 97156-PAM ADAPT BHV TX GDN PHY/QHP	U1	48	Modified
<b>Attachment Information</b>						
<b>Attachments</b>						
#	Transmission Method	File	Control #	Attachment Type		
1	FT-File Transfer	35 Treatment Plan January 2021.pdf	20210104911999	08-Plan of Treatment		
2	FT-File Transfer	35 VBMAP score sheet January 2021.pdf	20210104982591	09-Progress Report		
3	FT-File Transfer	35 Treatment Plan January 2021.docx	20210107621326	08-Plan of Treatment		
4	FT-File Transfer	ABA No therapy signature.jpeg	20210107387564	77-Support Data for Verification		
<b>Indiana Administrative Codes/Descriptions</b>						
No IAC Text exist for this Authorization						
<b>Analyst Remarks</b>						
Date	Line Number	Remarks				
01/06/2021	1	This prior authorization request has been suspended, not denied. The term "suspended" means the decision cannot be made until additional information is received. If this information is not received within 30 calendar days of the original suspension date, the request will be denied. In order to complete the review, please note this PA number clearly on the system update, and include the following information: Please provide the date that the member began ABA Therapy. This may have been with a different provider. Thank You				
01/12/2021	2	Consultant Review: This request has been suspended - not denied - for consultant review. Following that review, a determination letter will be sent. Thank you.				
01/13/2021	3	Prior Authorization is not a guarantee of payment. Per 405 IAC 5-3-7: the provider assumes responsibility for verifying the recipient's eligibility on the service date. The dates of this request overlap with the dates of a previously submitted request. The approved dates of service have been adjusted to avoid this overlap.				
<a href="#">System Update</a> <a href="#">Print Preview</a>						

## Update PA Requests on the Portal

The *View Authorization Response* panel enables the original requesting provider to submit updates to existing PA requests, as long as the request has not been denied:

1. Click **System Update** at the bottom of the associated *View Authorization Response* page ([Figure 10](#)).
2. The Portal displays the *Resubmit Authorization* page ([Figure 11](#)), including the panels from the authorization and additional sections.
3. In the *System Update Information* panel, indicate the desired updates as follows:
  - Use the Line Item field to enter the number of the service line to be edited. If the update applies to the entire authorization, enter **0** in the Line Item field.
  - Use the Message field to provide an explanation of what needs to be changed.
4. Click **Add**.
5. You can also add additional attachments, if needed, using the *Attachments* panel. (If submitting attachments separately, by fax or by mail, add a message to the *System Update Information* panel stating that the attachment is being sent, and type **0** as the line item.)
6. Click **Resubmit**.
7. The system displays the PA for your review. If all the information is correct, click **Confirm**.

*Note: Only the provider that submitted the original PA request (or authorized delegate of that provider) can use the System Update feature. This feature is not available for denied requests.*

System updates cannot be used to add new services to the original request, but they may be appropriate for making corrections to a pending request or to request an extension or additional units for an approved service. See the [Updating PA Requests](#) for more information.



Figure 11 – System Update – Resubmit Authorization

**Resubmit Authorization: E163260001** ?

Any forms relating to Authorization requests can be found [here](#).

\* Indicates a required field. [Expand All](#) | [Collapse All](#)

---

**Requesting Provider Information** [-]

Provider ID  ID Type  NPI Taxonomy  Name

---

**Member Information** [-]

Member ID  Birth Date   
Last Name  First Name

---

**Rendering Provider Information** [-]

Provider ID  ID Type  NPI Name   
Taxonomy

---

**Message Information** [-]

Message

---

**Diagnosis Information** [-]

Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.  
Do not use a decimal point when entering the Diagnosis Code.

Diagnosis Type	Diagnosis Code	Action
ICD-10-CM	G114-HEREDITARY SPASTIC PARAPLEGIA	<a href="#">Remove</a>

---

**System Update Information** [-]

Enter the Line Item number (use 0 if the update applies to the entire Authorization, not a specific Line Item) and a description of the update to be applied.  
Click the **Remove** link to remove an entry.

Line Item	Message	Action
<input type="checkbox"/> Click to collapse.		
*Line Item <input type="text"/>	*Message <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Cancel"/>		

---

**Service Details** [-]

Click '+' to view or update the details of a row. Click '-' to collapse the row. Click **Copy** to copy or **Remove** to remove the entire row.

+/-	From Date	To Date	Code	Modifiers	Units	Action
<input type="checkbox"/>	11/21/2016	11/21/2016	A9999-DME SUPPLY OR ACCESSORY, NOS			

---

**Attachments** [-]

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
<input type="checkbox"/> Click to collapse.					
	*Transmission Method <input type="text" value="FT-File Transfer"/>	*Upload File <input type="button" value="Choose File"/> No file chosen		*Attachment Type <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					

---

## Maintain Favorite Providers

Portal users can create a “favorite providers” list for facilities or practitioners that they frequently enter in their authorization requests. The list can include up to 20 providers and may be sorted by provider name or ID.

### Creating a Favorite Providers List

There are two ways to add a favorite provider to the list:

- Select the Maintain Favorite Providers option from the Care Management tab to access the *Favorite Providers for Authorizations* panel (Figure 12). Enter the favorite provider’s Provider ID or NPI and select ID type (either Provider ID or NPI) and then click **Add**. (If you do not know the Provider ID or NPI, you can use the magnifying glass next to the Provider ID field to search for the provider information.)
- You can also add providers to your favorites list during the PA request process by checking the **Add to Favorites** checkbox in the *Rendering Provider Information* section (Figure 13).

Figure 12 – Favorite Providers for Authorizations

**Favorite Providers for Authorizations**

The providers on the list below will be available for selection as the servicing provider when you are creating an authorization. You may have up to 20 providers on your favorites list. To add a new provider enter the Provider ID and ID Type, then click Add. If you do not know the ID and type, click the magnifying glass for a provider look up. To delete a provider, select the Remove link in the row.

\* Indicates a required field.

\*Provider ID   \*ID Type  Name

Seq	Provider Name ▲	Provider ID	Taxonomy	Street	City	State	Zip Code	Action
1	XXXX XXXXXX	0000000001		0001 XXStreet	Indianapolis	IN	46204	<a href="#">Remove</a>
2	XXXXXX XXXXX	0000000002	0000X0000X	001 E XXStreet SUITE 000	INDIANAPOLIS	IN	46237-6398	<a href="#">Remove</a>

Figure 13 – Add to Favorites Checkbox

**Rendering Provider Information**

Either select Rendering Provider from Favorites or enter ID, ID Type and Taxonomy (as needed). Select Service Type for this Authorization.

Rendering Provider same as Requesting Provider ☒

Select from Favorites

\*Provider ID  \*ID Type  Name

Taxonomy

\*Service Type

To remove a provider or facility from the favorite providers list, click **Remove** in the Action column on the *Favorite Providers for Authorization* panel.

### How Do I Use the Favorite Providers List?

When you create an authorization request, the *Rendering Provider Information* section (and the corresponding section for the service details) includes a Select from Favorites drop-down list. If the desired provider is on your saved favorites list, you can use this option to automatically populate provider information.



Figure 14 – Select from Favorites Options

**Requesting Provider Information**

Requesting Provider Information

Provider ID 5005005005 ID Type NPI Taxonomy \_

**Member Information**

Enter Member ID, Date of Birth and at least one character of First and Last Name

\*Member ID 100100100100

\*Last Name XXSmith

**Rendering Provider Information**

Either select Rendering Provider from Favorites or enter ID, ID Type and Taxonomy (as ne

Rendering Provider same as Requesting Provider ☒

Select from Favorites

\*Provider ID 5005005005 \*ID Type NPI

Taxonomy

\*Service Type SURGICAL

**Service Details**

Click '+' to view or update the details of a row. Click '-' to collapse the row. C

	From Date	To Date	Code
+	04/02/2015	04/02/2015	49999-ABDOMEN SURGERY PROCEDURE

Click to collapse.

\*From Date To Date

Modifiers

\*Units Dollars

Message

Rendering Provider (if different from above):

Select from Favorites

Provider ID ID Type Taxo

Add Service Cancel Service

## Submitting PA Requests by 278 Electronic Transaction

The 278 electronic transaction provides standard data requirements and content for all users who request and respond to prior authorization (PA) or certification requests. The 278 transaction supports the following information:

- Submission of initial electronic requests
- Submission of updated or revised electronic requests
- Submission of paper attachments for electronic requests
- Submission of retroactive electronic requests
- Submission of out-of-state electronic requests
- Submission of electronic administrative reviews
- Response with approval
- Response with modified approval
- Response with denial of a previous request
- Response with follow-up action code
- Response with action code

*Note: Requests for administrative review and appeals of PA decisions must be submitted in writing, even if the PA request itself was submitted electronically. See the [Prior Authorization Administrative Review and Appeal Procedures](#) section for instructions.*

Providers wanting information about the 278 transaction for submitting electronic PA requests should contact the Electronic Data Interchange (EDI) Solutions Unit at [INXIXTradingPartner@dxc.com](mailto:INXIXTradingPartner@dxc.com).

*Health Insurance Portability and Accountability Act (HIPAA)* legislation mandates that many of the major healthcare electronic data exchanges, such as electronic submission of PA requests and the electronic responses, are standardized national formats for all payers, providers, and clearinghouses. All providers who submit affected data electronically to the IHCP must use the mandated HIPAA formats. HIPAA specifically names several electronic standards that must be followed when certain healthcare information is exchanged. These standards are published as *National Electronic Data Interchange Transaction Set*

*Implementation Guides* – commonly called Implementation Guides (IGs). An addendum to each IG was also published and must be used with the IG to properly implement each transaction. IGs and addenda are available for purchase and download from the [Washington Publishing Company website](http://wpc-edi.com) at wpc-edi.com.

The IHCP developed technical companion guides to help users understand the IHCP requirements for each electronic transaction. The information contained in the IHCP companion guides is intended only to supplement the adopted IGs and provide guidance and clarification as they apply to the IHCP. The IHCP companion guides are never intended to modify, contradict, or reinterpret the rules established by the IGs. For IHCP-specific guidelines related to the 278 transaction, see the *278 Prior Authorization Request and Response* companion guide on the [IHCP Companion Guides](http://in.gov/medicaid/providers) page at in.gov/medicaid/providers.

All healthcare organizations exchanging HIPAA transaction data electronically with the IHCP are required to establish an EDI relationship. Entities with this EDI relationship are referred to as trading partners. The IHCP has prepared information to assist entities with becoming IHCP trading partners. In addition, providers wanting to submit electronic PA requests must follow the testing requirements as outlined by the IHCP. See the [EDI Solutions](http://in.gov/medicaid/providers) page at in.gov/medicaid/providers for additional information about the testing process or to obtain copies of testing instructions. The [Electronic Data Interchange](#) module also provides more information. Providers may also contact the EDI Solutions help desk by email at [INXIXTradingPartner@dxc.com](mailto:INXIXTradingPartner@dxc.com) or by telephone at 1-800-457-4584.

## Data Elements

The *278 Prior Authorization Request and Response* companion guide provides information about data elements that are required or situational for submitting a 278 transaction for PA. Data elements that could require more detailed explanations are discussed in the following sections.

## Certification Type Codes

*Certification type codes* are required data elements used in the 278 transaction to indicate the kind of certification requested. These codes are also found in the 278 IG. When submitting an electronic request for PA, the requester *must* use one of the certification type codes listed in Table 5 to specify the type of request needed.

Table 5 – Certification Type Codes

Code	Description	Usage
1	Appeal – Immediate	Informs the IHCP the request is for an administrative review Use this value only for appeals of review decisions where the level of service required is emergency or urgent.
2	Appeal – Standard	Informs the IHCP the request is for an administrative review
3	Cancel	Indicates the request was previously submitted but is being canceled by the requester
4	Extension	Indicates the request is for an extension request to a previously approved PA
I	Initial	Indicates a new request
R	Renewal	Indicates an update to renew the PA, not extend it
S	Revised	Indicates a request for a change or update to a previously approved PA for which services have not been rendered

## Service Type Codes

*Service type codes* are used in the 278 transaction to identify the classification of service for the PA request. This data element is required if known by the submitting provider. A complete list of service type codes is provided in the 278 IG.

Examples of service type codes are as follows:

- 12 – Durable medical equipment (DME)
- 45 – Hospice
- 54 – Long-term care

## Facility Type Codes

*Facility type codes* identify the type of facility where services are performed. This data element is *required*. The two categories of facility type codes follow:

- Uniform Billing Claim Form Bill Type (type of bill)
- Place of service (POS)

A list of the type of bill codes is available in the named code sources listed in the 278 IG for the specific facility type code. See the [National Uniform Billing Committee \(NUBC\)](https://www.nubc.org) website at nubc.org for a current list of type of bill codes.

A list of POS codes is available on the [Place of Service Code Set](https://www.cms.gov/medicare/medicaid-services) page on the Center for Medicare & Medicaid Services (CMS) website at cms.hhs.gov.

The provider is responsible for using current codes maintained by the entity responsible for the code set.

## Level-of-Service Codes

*Level-of-service codes* are used to indicate that the request is for an emergency service and is a situational data element. Emergency services do not require PA; however, any resulting inpatient stay does require PA, with the exception of inpatient stays for burn care with an admission of type 1 (emergency) or type 5 (trauma). Providers must use one of the following level-of-service codes to indicate an emergency request:

- 03 – Emergency
- U – Urgent

## Release of Information Codes

*Release of information codes* are used to indicate that the provider has a statement on file, signed by the member, authorizing the release of the member's medical information. Providers *must* use one of the current codes listed in Table 6.

Table 6 – Release of Information Codes

Code	Description
A	Appropriate release of information on file at healthcare service provider or utilization review organization
I	Informed consent to release medical information for conditions or diagnoses regulated by federal statutes
M	Provider has limited or restricted ability to release data related to a claim
O	On file at payer or at plan sponsor
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim

## UMO Information

Electronic PA requests are submitted individually or in batch files. Each request must contain the name and identifier of the utilization management organization (UMO):

- All admission requests for nursing facilities (specialty 030) and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) (specialty 031) are forwarded to the Long Term Care (LTC) Unit.
- All other nonpharmacy PA requests are reviewed by the appropriate PA contractor based on the program assignment of the member.

The UMO information listed in Table 7 is required for 278 request submissions.

Table 7 – UMO Information for FFS, Nonpharmacy PA

Data Element	Long-Term Care Requests	All Other Requests
UMO Name	LTC Unit	Gainwell
UMO Identifier	LTC Unit	Gainwell

## Segments

A segment is a unit of information in the electronic transaction. The [278 Prior Authorization Request and Response](#) IHCP companion guide provides detailed information about segments that are required or situational for submitting a 278 transaction requesting PA. Segments requiring more explanation are discussed in the following sections.

### Diagnosis Segment

The Diagnosis segment of the 278 transaction allows providers to submit up to 12 International Classification of Diseases (ICD) codes for a single patient event. A patient event is defined as: *The service or group of services associated with a single episode of care.* The ICD code is a required data element and must be submitted after the appropriate diagnosis type code.

### Previous Certification Identification Segment

The Previous Certification Identification segment is required when a provider submits an additional request associated with a previously approved PA and the provider knows the previous PA request number.

### Procedures Segment

The Procedures segment of the 278 transaction is used to request specific services and procedures and is required for all IHCP electronic PA requests. The 278 IG lists various procedures on the *Code List Qualifier* used to designate the specific procedure code. However, the IHCP processes only procedure codes defined under the *ABR – Assigned by Reviewer* and *BO – Healthcare Common Procedure Coding System (HCPCS)* code sets.

- Revenue codes are reported under ABR.
- The American Medical Association (AMA) Current Procedural Terminology (CPT) codes are reported under BO.
- The American Dental Association (ADA) Current Dental Terminology (CDT) codes are considered level II HCPCS codes and are reported under BO.

Logical Observation Identifiers, Names, and Codes (LOINC) identify specific information concerning the patient or services that the UMO requires from the provider to complete the medical review. The LOINC are addressed in the 5010 version of the 278 IG. However, the LOINC **are not to be used** with the 278 transaction for processing IHCP PA requests at this time.

### *Units*

Providers can submit PA requests for service units or for specific dollar amounts. For example, HCPCS code E8000 – *Gait trainer, pediatric size, posterior support, includes all accessories and components* is used to identify the device. The *Message (MSG)* segment of the 278 request is used to identify the specific type of device for the PA request. HCPCS code E8000 includes the accessories associated with the device; providers cannot submit separate codes for the accessories.

### **Message Segment**

The 278 transaction allows providers to submit a free-form message about the request. The *MSG* segment allows a free-form text field of up to 264 characters.

### *Procedure Code Modifiers*

When submitting a PA request that contains a CPT or HCPCS modifier, providers must use the *MSG* segment in the 278 transaction. This format accommodates reporting modifiers for up to 12 procedure codes. The procedure for the reported modifier is identified in the *MSG* segment by the corresponding HI element where the procedure is located. The 278 IG provides information about submitting a request that contains both a modifier and a text message in the *MSG* segment.

### *Retroactive Prior Authorization*

PA is given after services have begun or supplies have been delivered only under the circumstances outlined in the [Retroactive Prior Authorization](#) section of this module. When a retroactive request is submitted with the 278 transaction, providers must indicate in the *MSG* segment of the request that the request is for a retroactive PA.

### *Request for Transportation Services*

When submitting a transportation PA request with the 278 transaction, the following information is required in the *MSG* segment of the request. Unlike when submitting a paper request for PA, an attachment is not required when the *MSG* segment provides this information:

- Member's condition
- Type of service required, such as wheelchair van, commercial ambulatory service (CAS), or taxi
  - The member's condition must support the level of service requested.
- Reason for and destination of service, such as dialysis or physical therapy treatments
- Frequency of service and treatment per the physician's order, such as twice per week
- Duration of service and treatment per the physician's order, such as 3 months
- Total mileage for each trip, such as 129 miles
- Total waiting time for each trip, such as 2 hours

### ***Duplicate Requests for Nonspecific Codes***

Duplicate 278 requests for the exact same date of service, exact same procedure, and exact same requesting provider for the same member are systematically rejected. Duplicate requests submitted for unspecified procedure or service codes are manually reviewed.

Providers must use the *MSG* segment of the 278 transaction to identify the specific procedure or service submitted for the unspecified code to avoid rejection. For example, when submitting HCPCS code E1399 – *Durable medical equipment, miscellaneous*, providers must indicate in the *MSG* segment the specific equipment requested.

To avoid rejection as a duplicate of another request, procedures or services that are repeated for the same date of service must be submitted with one of the modifiers in Table 8. These modifiers must be documented in the *MSG* segment corresponding to the appropriate procedure code in the corresponding *HI* segment. This requirement does not refer to requests submitted for multiple units for the same procedure or service on the same date of service on the PA service line.

**Table 8 – Repeated Services Modifiers**

<b>Modifier</b>	<b>Description</b>
76	Repeat procedure by same physician
77	Repeat procedure by another physician
91	Repeat clinical diagnostic laboratory test

### ***Paper Attachments for 278 Electronic PA Requests***

The IHCP accepts paper attachments with an electronic PA request. The 278 transaction does not support electronic attachments at this time.

When a 278 request transaction requires submission of additional documentation, the documentation must be submitted as a paper attachment. When a provider sends a paper attachment with a 278 transaction, the following information must be included on the 278 transaction in the *Additional Patient Information* segment:

- *Attachment Transmission Code* – Indicates an electronic request has paper documentation to support the requested services. This code defines the timing and transmission method or format of the reports and the method of submission. This value is provided in *Attachment Transmission Code, Data Element 756*, on the 278 transaction. All valid *Attachment Transmission Codes* are accepted for the 278 transactions; however, the IHCP accepts only paper attachments for electronic or paper PA requests by mail and fax. The IHCP uses the following *Attachment Transmission Codes*:
  - BM – *By mail*
  - FX – *By fax*
- *Attachment Report Type Code* – Indicates the type of attachment being sent to the IHCP that supports the 278 request data. The code indicates the title or contents of a document, report, or supporting item. This code is used in *Report Type Code, Data Element 755*. For a complete listing of *Attachment Report Type Codes*, see the 278 IG. Examples include the following codes:
  - B3 – *Physician order*
  - DS – *Discharge summary*
  - OB – *Operative note*
- *Attachment control number (ACN)* – Identifies each attachment. The ACN is created by the provider and must consist of at least two, and no more than 30, characters. The IG allows for 80 characters; however, the IHCP processes only 30 characters. This code is used in *Attachment Control Number, Data Element 67*.

The following instructions are for submitting paper attachments for electronic claims:

- Each paper attachment submitted for a 278 transaction must include a unique ACN. Write the unique ACN on each attachment.
- An attachment with multiple pages must have the ACN on each page.
- A maximum of 10 attachments is allowed per service level and 10 per subscriber level.
- The ACN must be unique per document, and documents cannot be shared between requests.
- Providers must write the ACN, Member ID (also known as RID), National Provider Identifier (NPI) or Provider ID, and date of service on each attachment to ensure that the attachment is linked to the appropriate request.
- Paper attachments must be sent to the appropriate PA contractor. For fee-for-service (FFS), nonpharmacy PA requests, paper attachments must be mailed or faxed to Gainwell at the following address:

**Gainwell – Prior Authorization**  
**P.O. Box 7256**  
**Indianapolis, IN 46207-7256**  
**Fax: 1-800-689-2759**

If the attachments are not received within 30 calendar days of the request submission, the request is denied. If attachments are received, and one specific attachment needed for processing is missing, the provider may receive an electronic response indicating additional information is needed to process the request.

## ***278 Response***

A 278 response transaction is communicated to the provider indicating approval, approval with modification, or denial of a request for all electronic PA requests. An electronic response is not provided for paper requests. The *Health Care Services Response* section of the 278 IG allows the payer – the IHCP, in this case – to perform the following functions:

- Provide a response to each 278 request received
- Provide a short text message to the provider regarding what is needed, such as missing information needed to process the request
- Provide a reason for rejection
- Provide information indicating the PA status
- Request an attachment
- Return information received on the request to the provider
- Continue to send providers a paper notice

## **Action Codes**

The PA reviewer assigns a PA status code to each request, identifying the type of action taken. These status codes are converted to standard action codes that appear on the 278 response. Requesting providers receive the 278 response with this review outcome information. These action codes are returned only if the appropriate PA contractor is able to review the request.

Table 9 – Action Codes

Code	Description
A1	Certified in total
A3	Not certified
A4	Pended
A5	Modified
NA	No action required

Providers continue to receive paper notification for PA in addition to an electronic response. See [Table 1](#) for the PA notification letter responses (administrative working status) associated with each of these action codes.

## Reject Reason Codes

*Reject reason codes* may be returned to the provider when the system rejects the 278 transaction before review by the PA contractor. Providers receive a 278 rejection response for requests that cannot be processed at a system or application level, based on the information submitted. The 278 IG provides a complete list of *Reject Reason Codes*. Some examples of rejection are as follows:

- Subscriber/Insured not in Group/Plan Identified
- Invalid diagnosis or dates
- Missing service codes and dates
- Exact duplicate of another request

The provider also receives a *follow-up action code* identifying the action the provider must take to correct the transaction rejection. Providers do not receive paper notification of system-generated rejections.

## Submitting PA Requests by Telephone

*Note: The information in this section is specific to FFS nonpharmacy PA requests. For policies and procedures related to telephone PA requests for FFS pharmacy services or for managed care services, contact OptumRx or the member's MCE, respectively.*

PA telephone requests are appropriate to facilitate hospital admission or discharge, to maintain the health and well-being of the member, or when emergency services are required. Examples of services prior authorized by telephone include, but are not limited to, nutritional feedings, extended stays for burn therapy and rehabilitation, and out-of-state requests.

Verbal notification (with written notification to follow) of approval, modification, or denial is given when the call is made for the following services:

- Inpatient hospital admission
- Concurrent review, when required
- Continuation of retroactive PA for emergency treatment on an inpatient basis
- Surgeries or other treatments that approach or exceed the cost limits or utilization review parameters found in the IAC
- Medically necessary services or supplies that facilitate discharge from a hospital or prevent admission to a hospital



- Equipment repairs necessary for the life support or safe mobility of the patient
- Medical services when a delay in beginning the services could reasonably be expected to result in a serious deterioration of the patient's medical condition

## ***Telephone PA Exclusions***

Telephone PAs are not approved for the following:

- Services that can otherwise be authorized in writing, such as routine office visits
- Trend events, such as specialized therapies and continued home health care services
- Elective surgeries
- Retroactive requests for nonemergency services
- Extension of existing PAs

## ***Telephone PA Procedures***

An *IHCP Prior Authorization Request Form* is not necessary for telephone PA services. However, additional written substantiation and documentation may be required.

The [IHCP Quick Reference Guide](https://www.in.gov/medicaid/providers) at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers) is the primary source for prior authorization contact information, including for managed care PA contractors.

The telephone number for FFS, nonpharmacy PA requests is:

**Gainwell Prior Authorization and Utilization Management (PAUM) Unit**  
**1-800-457-4584, option 7**

This toll-free number is available throughout Indiana and to providers located in designated or contiguous areas of Illinois, Kentucky, Michigan, and Ohio. Telephone lines are staffed from 8 a.m. to 5 p.m. Eastern Time, Monday through Friday, excluding holidays.

The Gainwell PA telephone line has an automated attendant to direct calls to the appropriate area. The automated attendant offers the following options:

- Option 1 – Durable Medical Equipment (DME) and Audiology
- Option 2 – Physical Therapy, Occupational Therapy, or Speech Therapy
- Option 3 – Home Health
- Option 4 – Elective Inpatient Stay
- Option 5 – Mental Health
- Option 6 – Medicaid Rehabilitation Option (MRO)
- Option 7 – Hospice
- Option 8 – Dental and Transportation

Providers should access the appropriate option for the PA question.



## Section 4: Prior Authorization Administrative Review and Appeal Procedures

Prior authorization (PA) administrative review and appeal procedures are outlined in the *Indiana Administrative Code* (IAC) sections 405 IAC 5-7 and 405 IAC 1.1. Appeals on Indiana Health Coverage Programs (IHCP) PA issues are conducted in accordance with 405 IAC 1.1. For all PA decisions, a *Notice of Appeal Rights* is sent with the PA notification letter, outlining the procedures to be used.

Administrative reviews are completed by the PA contractor that denied the request. If the administrative review is submitted to the incorrect PA contractor, the request will be returned to the provider for submission to the appropriate organization for review. If the member has been assigned to a different program since the request for PA was denied, providers can either appeal to the PA contractor that denied the request *or* submit a new PA request for review to the correct PA contractor.

The information in this section pertains to fee-for-service (FFS), nonpharmacy PA requests. Administrative review and appeals of these PA decisions are handled by Gainwell.

*Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise PA requests, the member or provider should contact the member's managed care entity (MCE) Member Services or Provider Services toll-free number for information about how to submit a grievance or appeal. See contact information in the [IHCP Quick Reference Guide](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

*For information about FFS pharmacy-related PA appeals, see the [Pharmacy Services](#) module.*

### Administrative Review of PA Decisions

A provider requesting review of the modification or denial of a PA must request an administrative review within **7 business days** of the receipt of notification of modification or denial.

When administrative review is desired but the member continues to be hospitalized, Gainwell must receive a letter notifying the Prior Authorization and Utilization Management (PAUM) Appeals Unit of the *intent to request an administrative review* within 7 business days of the receipt of notification of modification or denial. If the provider wants to continue with the appeal, Gainwell must receive the entire medical record within 45 calendar days after discharge. Failure to request a timely administrative review as outlined in 405 IAC 5-7-2(b) results in the loss of the right to request an administrative hearing.

*Note: If the program assignment of the member has changed since the denial of the initial PA request, a new PA request may be submitted to the appropriate PA contractor based on the new program assignment of the member.*

To initiate an administrative review, providers must include the following information with the request:

- Copy of the original IHCP PA request form (or printout of the electronic PA request)
- Summary letter, including pertinent reasons the services are medically necessary and the following:
  - PA number
  - Member's name
  - IHCP Member ID (also known as RID)

- All documentation, including medical records, equipment consultations, progress notes, case histories, and therapy evaluation
  - Documentation should be pertinent to the case and support the medical necessity of the requested service.
  - For authorization review requests for inpatient hospitalizations, the entire medical record must be included.
- Name, telephone number, and address of the provider submitting the request
  - This information is required in the event it is necessary to contact the provider for additional information or clarification.

This information should be faxed to Gainwell at **1-866-368-2644** or mailed to the following address:

**Administrative Review  
Gainwell – Prior Authorization  
P.O. Box 7256  
Indianapolis, IN 46207-7256**

The Gainwell IHCP medical director or designee renders the administrative review decision of the contractor within 7 business days of receipt of all necessary documentation. The requesting provider and member receive written notification of the decision containing the following information:

- The IHCP contractor determination and the rationale for the decision
- The *Notice of Appeal Rights* through the Indiana Family and Social Services Administration (FSSA)

## Administrative Hearing Appeal Process for PA Decisions

The following subsections address the administrative hearing appeal process for providers and members.

### ***Provider Appeals of Prior Authorization Decisions***

Any provider that has submitted a request for prior authorization can appeal a denial or modification of the request after exhausting the administrative review process. The appeal request must be in writing and must be signed by the requesting provider or designee. Provider appeals of PA decisions are conducted in accordance with the member appeals regulation, *405 IAC 1.1*.

Provider requests for administrative hearings must be submitted within 33 calendar days of the administrative review decision to the following address:

**Office of Administrative Law Proceedings  
FSSA Hearings and Appeals  
402 W. Washington St., Room E034  
Indianapolis, IN 46204**

### ***Member Appeals of Prior Authorization Decisions***

If a member disagrees with a denial or modification of a PA request, the member can ask for a hearing (pursuant to *Code of Federal Regulations 42 CFR 431.200 et seq.* and *405 IAC 1.1*) by filing an appeal as described in this section. An administrative review by the PA contractor is not required before a member files a request for a hearing with the FSSA.

Members of managed care programs, including HIP, Hoosier Care Connect, and Hoosier Healthwise, must first exhaust their MCE's appeal process before submitting an appeal to the FSSA.

Members can appeal a PA decision by writing a letter explaining why they think the decision is wrong. The letter must be signed and must include the member's name and other important information, such as the date of the decision. Requests for administrative hearings should be sent to the following address:

**Office of Administrative Law Proceedings  
FSSA Hearings and Appeals  
402 W. Washington St., Room E034  
Indianapolis, IN 46204**

If the appellant is not the member, documentation that the appellant has the legal right to act on behalf of the member, such as power of attorney for healthcare or legal guardianship papers, must accompany the request.

The filing must be within 33 calendar days of the date the adverse decision was received or takes effect, whichever is later. If the request is for a continuing service (for example, home health care), at least 10 days' notice plus 3 days' mailing time must be given before the effective date of the denial or modification, except as permitted under *42 CFR 431.213* and *42 CFR 431.214*.

As required by statute, if the request for a hearing is received before the effective date of the denial or modification of continuing services, services are continued at the authorized level of the previous PA.

For additional information regarding the member appeals process, see the *Member Appeals* section of the [Member Eligibility and Benefit Coverage](#) module.